Nutrition & Dietetics Paediatric Referral Form

The St George Hospital
2nd floor, Prichard Wing
KOGARAH NSW 2217
Phone: 9113 2752 Fax: 9113 2847

Please fax this referral to our office, we will arrange an appointment and notify the parents of the date and time.

Date: ___/___/____

Name of referring Doctor: _____ Phone: _____

Patient's Name: _____

Parent's Name: _____ Phone: _____

Address: _____

MRN (if applicable): _____

DOB (note if premature): _____

Current height: _____

Current bare weight: _____

Reason For referral:

- ☐ FTT
- ☐ NG / Gastrostomy feeding
- ☐ Fussy eating with diagnosed nutrient deficiency (note: fussy eating referrals without co morbidity will not be accepted)
- ☐ Diagnosed food allergy
- ☐ Overweight or obese children (BMI above the 85th percentile for age)
- ☐ Inappropriate feeding practices for age
- ☐ Diet related constipation
- ☐ Other (as deemed appropriate by paediatrician)

Additional Information: (relevant med Hx, social Hx, meds, allergies, interpreter required)

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